# EMERGENCY CLAIM FORM

Membership Number / Expiry Date

In accordance with the Health International Terms & Conditions, as stated in the Membership Guide Section 10, any Member visiting a medical facility for the purpose of EMERGENCY treatment is required to do the following:-

A. **NOTIFY THE REGIONAL OFFICE WITHIN 72 HOURS OF THE EVENT** (by telephone / email / text / visit).

B. **COMPLETE THIS EMERGENCY CLAIM FORM AND SUBMIT TO THE CLAIMS DEPARTMENT** (see details below).

C. **MEMBERS ARE REMINDED THAT SHOULD THIS CASUALTY VISIT BE A NON-EMERGENCY / OUT-PATIENT CLAIM, IT MAY BE DECLINED. IF YOU ARE UNSURE, KINDLY CALL THE CLAIMS DEPARTMENT ON THE FOLLOWING NUMBER +263 (0) 782 444 555**

Failure to comply with the above will lead to repudiation of the claim.

**MEMBERS INFORMATION: (As Per Your Health International Membership Card)**

| | | | |
|---|---|---|---|
| Name of Principal Member: | | | |
| Contact Telephone No: | | Mobile: | |
| Full Name of Patient: | | | |
| Patient Date of Birth: | DD / MM / YYYY | | |
| Membership No: | | Membership Expiry Date: | |

**COMPLETION OF THIS SECTION IS COMPULSORY:**

| | | |
|---|---|---|
| **REASON FOR EMERGENCY VISIT:** Please Tick The Applicable Box | ☐ **ACCIDENT** | ☐ **ILLNESS** |
| **DATE OF EMERGENCY:** | **TIME OF EMERGENCY:** | |
| **FULL DESCRIPTION OF THE EMERGENCY:** | | |
| | | |
| | | |
| | | |
| | | |

| | |
|---|---|
| Name of Emergency Facility: | |
| Name of Treating Doctor or Specialist: | |
| (PLEASE INCLUDE CONTACT DETAILS IF AVAILABLE) | |

| **INVESTIGATIONS RELATED TO THE EMERGENCY:** | | |
|---|---|---|
| RADIOLOGY (X-RAY / MRI SCAN / C.T. SCAN ETC.) | ☐ YES | ☐ NO |
| PATHOLOGY (BLOODS / SPECIMEN URINE / STOOL ETC.) | ☐ YES | ☐ NO |

Member's Signature _____ Date (DD / MM / YY) _____ Place: _____

I understand that Health International will collect and process my personal data as per Clause 9.10 of the Terms and Conditions.


TRILOGY BENEFITS GROUP

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